MHDS Redesign Regional Workgroup

Meeting #1
August 16, 2011, 10:00 am to 3:00 pm
Altoona Public Library
700 8th Street S.W., Altoona, IA

MINUTES

Attendance

Workgroup Members: Jane Arnold, Tom Eachus, Lori Elam, Donna Harvey, David Hudson, Sarah Kaufman, Bob Lincoln, Charles Palmer, Sally Stutsman, Mary Vavroch, Suzanne Watson

Legislative Representation: Renee Schulte, State Representative, House District 37 (Linn County) and Co-chair of the Legislative Interim Committee on MHDS Redesign

Facilitator: Steve Day, Technical Assistance Collaborative (TAC)

DHS Staff: Connie Fanselow, Deborah Johnson, Robyn Wilson, Joanna Schroeder, Jen Harbison

Other Attendees:

Ami Anderson	Polk County Board of Supervisors
Bob Bacon	Center for Disabilities and Development (CDD)
Linda Hinton	Iowa State Association of Counties (ISAC)
Sandi Hurtado-Peters	Department of Management (DOM)
Ken Hyndman	Des Moines County CPC
Steve Kerber	Appanoose County CPC
Brice Oakley	Iowa Alliance of CMHCs
Kelley Pennington	Magellan Health
John Pollak	Legislative Services Agency (LSA)
Donna Richard-Langer	Department of Human Services (Judicial DHS)
Karen Riggle	Van Buren County CPC
Ann Riley	Center for Disabilities and Development (CDD)
Steve Roberts	Disability Rights Iowa
Jean Rommers	Iowa Association of Community Providers (IACP)
Joe Sample	Iowa Department on Aging (IDA)
Kim Scorza	Seasons Center
Julie Smith	Iowa Health System
Karen Walters-Crammond	Polk County Health Services
Ben Woodworth	Iowa Association of Community Providers (IACP)
Joel Wulf	Iowa Department on Aging (IDA)
Michelle Zuerlein	United States Psychiatric Rehabilitation Assn. (USPRA)

Agenda

Agenda Topics:

- Workgroup Overview and Introductory Remarks
- Group Discussion of Potential Role and Functions of Regions
- Group Discussion of the Benefits of a Regional Approach
- Group Discussion of Concerns about a Regional Approach
- Next Steps
- Meeting Summary
- Public Comment

WORKGROUP OVERVIEW AND INTRODUCTORY REMARKS

Introductory remarks by State Representative Renee Schulte:

2011 Legislative Session:

- Senate File 525 calls for reform of the mental health and disability services system in Iowa
- Senate File 209 sunset the Code creating the mental health tax levy and central point of coordination provisions at of July 1, 2013 with the intent to move reform forward

Why is reform needed?

- County property tax levy rates have been capped and most counties are levying to their maximum
- Iowa's county of legal settlement system for financial responsibility is outdated
- "Transactional friction" exists in the payment and administrative structure of the system
- Iowa has recently moved to a statewide waiting list
- Geographic inconsistencies and inequities in access to services exist

The goal of redesign is:

- To create a core level of services that all Iowans can expect no matter where they live
- To create flexibility for regions to be creative and make choices in how they might want to go beyond the core level of services

The Regional Workgroup will be expected to:

- Look at 28E or other types of agreements as a way of forming regions
- Make recommendations for forming regions that are legal, permanent, and responsible for the catchment area they serve
- Look at trends around the country
- Look at integration of care, such as medical or behavioral health homes
- Envision a transformed system with "no wrong door" that helps people get what they need and produces positive outcomes for the people being served

Introductory remarks by DHS Director Chuck Palmer:

Workgroup role and membership:

- The members of the Iowa General Assembly had differing viewpoints on how redesign should be accomplished
- The decision was to bring many of the issues to this series of workgroups
- This workgroup will discuss the pros and cons of a regional system for Iowa and what that might look like
- There are currently three places in the State utilizing a regional approach and this group can learn form their experience
- The members of the workgroups represent small, large, and medium sized counties
- County Board of Supervisors and Central Point of Coordination (CPC) Administrators have a key role in the regionalization discussion
- The General Assembly has expressed their intent to pursue a regional delivery system
- Workgroups need to provide specific recommendations for the Interim Committee

Redesign Workgroups:

- Regionalization
- Adult Mental Health Services
- Adult Intellectual Disability and Developmental Disability Services
- Children's Services
- Brain Injury
- Judicial Branch/DHS

Workgroup Formation:

- DHS received many applications for workgroup membership
- Including the Judicial Workgroup about 88 people are involved
- A few additional members may be added
- Workgroups to look at PMICs (Psychiatric Medical Institutions for Children) and information technology will also be convened
- Each group has a lot of work to do and meetings will be structured with subject matter defined for each session

Questions for Workgroup Discussion:

- What rules should be set by the State for the sake of consistency?
- How can regional entities work with local entities to ensure good outcomes for people and good local contractual relationships with providers?
- What constitutes a core level of services?
- What other services might be added to the core level ("core plus")?
- What are the levels of access to services?
- How can programs transcend county boundaries?
- What economies of scale can we build in?

Questions specific to regionalization:

- What are the criteria for a region?
- How does the definition of core services drive those criteria?
- How do we operationalize the regional concept?
- What type of governance does it need?
- What holds a region together?
- Can a single county be a region?
- What happens if a regional partner decides they don't want to participate?
- How do we bring people together in a collaborative manner to share a sense of stewardship?
- What is the role of Medicaid and other funding streams?

Goals:

- Create a new system that is good for Iowa
- Learn from different delivery models and similar redesign efforts in other states
- Borrow good ideas that will work well in Iowa
- Work toward some level of consensus
- If can't reach consensus on all points will share pros and cons and rationale of divergent viewpoints with Interim Committee
- The final goal is to do a better job serving the people of Iowa and move the mental health and disability services system into the 21st century
- The General Assembly direct us to come together to recommend a regional structure of some kind that we think will work for Iowa

Public input into the process:

- Workgroup meetings are open to the public
    - Time will be reserved at the end of each meeting for public comments
    - People who are observing are asked to hold their comments or questions until that time
    - Please limit them to the subject matter of that day's meeting
    - Please keep them brief and to the point
    - Please do not repeat comments that have already been offered
- There has been significant interest on the part of consumers, patents, and advocates in participation in this process
- Director Palmer has scheduled a meeting later this week with the heads of advocacy groups to help on developing an active input process
- DHS is sensitive to consumers and family members having an effective avenue to be heard
- Individuals may be invited to provide information to workgroups from time to time

Introductory remarks by Steve Day:

Steve Day shared handouts:

- Agenda for today's meeting

- Proposed agenda for future meetings
- Meeting Schedule
- Workgroup membership list
- Summary of Senate File 525
- Instructions for accessing the website
- Description of sites for meetings

Joanna Schroeder is managing the workgroup meeting process for DHS.

Technical Assistance Collaborative:

- Steve works for the Technical Assistance Collaborative (TAC), a non-profit with offices in Boston
- TAC works with states, localities, and non-profits all over the country
- TAC was formed 20 years ago with grant from the Robert Wood Johnson Foundation to work with states and counties around the issue of health reform
- Since then TAC has worked with 48 states and many localities on issues of getting good practice services to people with disabilities and mental health conditions
- TAC's primary mission is to work on behalf of people with disabilities to figure out the best ways to manage and access resources; they have also worked with CMS (Centers for Medicare and Medicaid Services) and SAMHSA (Substance Abuse and Mental Health Services Administration)
- Experienced working in Iowa with DHS, ISAC (Iowa State Association of Counties) and individual counties

Steve's observations:

- Most of the work that gets done for people is at the state and local level
- Most states have moved or are moving to regionalization in some form because
    - Resources are scarce and there needs to be some form of local system of care and consumer access/ care coordination. It is important to protect what is most valuable in your system and still find ways to do things differently and to balance this with efficiency, consistency, and accountability
    - Systems only work when there is commitment and buy-in among all the stakeholders
    - Implement what you believe in

Overview of Redesign process:

- There is a mutual interdependence between groups
- The work of this group cuts across and is dependent on the work of the other groups
- Each group will have a proposed agenda for the series of meetings
- Agenda will provide a logical sequence for the discussion
- Staff will provide information and materials to prepare workgroup members for discussions

What other states are doing:

- Every state is different
- There is no agreement on a best practice model
- In the northeastern states there is really no local role; they use a regional CMHC and statewide contracting for developmental disability services
- Some use managed care
- Some have a regional structure
- Some have state operated regional systems
- No consistency in optimal size for regions
- Some combine Medicaid and non-Medicaid funded services and some handle separately
- Some combine managed care waivers and HCBS Waivers
- Even in the strongest county system in the country some smaller counties struggle
- Some use regional managed care entities
- Some measure outcome and pay performance bonuses to providers, but allow them a large amount of flexibility
- Some use multi-service providers or consortiums of providers

GROUP DISCUSSION OF THE BENEFITS OF A REGIONAL APPROACH AND THE POTENTIAL ROLE AND FUNCTIONS OF REGIONS

What are the benefits of regions?

- Potential to do many of the things that are now done at the county level
- Easy, simple navigation for consumers and providers
- Access to information, people, programs, resources for consumers and providers
- Consistency of services, reimbursement rates and methods
- Everyone in regional area has access to all services
- System modeling – maintaining some standardization, yet doing some things differently
- Fostering new approaches and best practices
- Eliminating some of the bureaucracy of many separate systems
- Operational efficiencies such as Central/consistent billing system
- Broader array of services
- Provision of core services
- Equity of access to services
- Accomplish administrative efficiencies
- Spend more on what people want
- Economies of scale
- Allow for specialization of administrative and clinical staff
- Attract and retain providers and medical/mental health professionals, including psychiatrists
- Address workforce shortage issues
- More effective interface between regions and other systems

- Greater sensitivity to demographic and geographic differences than state control, balanced with some kind of local governance and commitment
- Opportunity to assume risk and use savings for reinvestment
- Improved data collection
- Eliminating time and energy related to legal settlement disputes
- Less funders could simply the billing process for hospitals and providers, resulting in administrative savings
- Make it easier for providers to do their jobs

Additional Discussion of the Role and Functions of Regions:

- Need operational efficiencies that focus on improving patient centered care
- If a plan saves money that's good; if a plan improves client outcomes that's better
- Some things have to be consistent
- Reasonable access to core services
- Different ways to accomplish those goals of consistency
- Need to decide how much discretion and entrepreneurship is to be encouraged locally
- Governance structure should support desired outcomes
- Outcome is defined; consistency
- How to achieve outcome can be up to the region; flexibility
- Sensitive to the needs to consumers and providers so how to access services looks the same to them
- Everywhere in the state people have roughly the same experience in accessing services
- Regions represent the place that you would hold accountable for people getting the right services at the right time
- Need one consistent way to access services
- Need a locus and structure of accountability
- Need stable funding mechanism (formula) for the Legislature that makes sense
- Legislators can see what they are funding and make it "automatic" (example of state funding for public education per pupil formula)
- Flexibility comes into how those dollars are used at the local level
- Data collection and capacity are important
- Goal that the data will be collected in an accurate and consistent way
- Recognize value of local cross system, multi system collaborations (housing, substance use, hospitals, shelters, etc.) that help negotiate barriers to accessing services and make things work better for people
- How do you protect/maintain those relationships at the local level?
- To really have impact on individuals you need local staff, local management even though you have administration on a regional level
- Use savings from economies of scale to fill gaps
- Change some of the locus of responsibility
- Envision a locally delivered service system with regional administration

What do we mean by locally delivered?

- Service coordination, access point happening at a local office
- CMHCs, county offices, jails, and hospitals are access points
- Core services groups will define level of access
- Legislation provides guidance on basic resource requirements for a region
- Regionally managed, locally accessed

How should counties be joined into regions?

- By mutual agreement to the extent possible
- On option would be to assign one or more counties to a region if natural partnerships are not formed
- Natural partnerships must meet minimum size/resource requirements to be viable
- There should be no county lines "visible" to clients in the delivery of MH/DD services
- Need to have enough money, resources, and people in the region to be managed effectively
- A population threshold could be recommended
- Suggestion of at least 300,000 people
- Must have a budget size, provider network, and resources to give people access
- Those needs might drive counties into larger groups than they would otherwise define
- The percentage of people needing services should be fairly constant across the state per capita
- Currently some areas have attracted more people needing services because that's where they could be accessed
- Not every county would necessarily have a full array of services
- But, every region should assure access to the defined core services
- How far should people have to travel – how far is too far?
- Will regions have to have a governing board?
- What gives the right level of local buy-in ad commitment?
- Consistency and knowing who you are doing business with are important
- An entity that can be held accountable for outcomes is necessary
- Legislative intent is that regional entities are made up of counties coming together
- Has to be a governance structure, a body that can meet the contractual obligations
- 28E Agreements are one option, which has certain legal requirements

GROUP DISCUSSION OF CONCERNS ABOUT A REGIONAL APPROACH

What are the concerns about going from counties to regions?

- Home rule; keeping local control within counties
- What legal parameters will we have to honor?
- Will bigger service area really improve access?

- Transportation/travel issues will still exist
- Will there be fewer access points?
- Don't want to make it harder to access services because of regional boundaries
- Residency requirements could cause just as many problems as legal settlement requirements
- Regions shouldn't have anything to do with where individuals get services; it should have to do with administration
- Administrative structure should be invisible to people using the system
- A centralized State system could be more efficient
- County workers might face job/employment changes
- Fear of losing county jobs
- Don't want to add another layer of bureaucracy; things at state and local level need to change as well
- When you become larger in scale is it can be harder to contact people and get answers
- State contracting directly with providers could be more efficient

NEXT STEPS:

Information requested for next meeting:

- Number and placement of:
    - Acute care psychiatric unit/beds
    - Mental Health Institutes
    - Federally Qualified Health Care Centers
    - Community Mental Health Centers
- County population numbers from 2010 census
- Maps of established regional structures in Iowa (judicial, community college, area agencies on aging/ADRC, area education agencies, DHS service areas, substance abuse service areas, etc.)
- Iowa Code Chapter 28E language
- Copy of Community Social Services 28E agreement?

Meeting 2 Agenda:

- Will discuss and develop criteria for creating regions.
- What would you need to qualify as a region?
- If you were going to bid on a performance contract with DHS to become a region; what conditions should it take to be a qualified applicant?
- Talk about regional functions
- Crisis services?
- Multi-system collaboration?

MEETING SUMMARY:

- Potential function of regions

- Service planning
- Designate access points
- Mechanism for reviewing service plans for non Medicaid services
- Mechanism for provider contracting and certifying provider participation; may include cost reporting
- Designation of targeted case management
- Regional quality management/quality improvement
- Mechanism for managing funds

- Pros and cons of a regionalized system

PUBLIC COMMENT:

Comment: Counties have invested in infrastructure, including county homes and residential care facilities. What will happen in 2013; will that infrastructure continue to be supported by the regions or replaced?

DHS Response: Those questions are among the reasons that it is important to clarify this process now so that people have time to plan. The intent of repealing the existing system by a date certain indicates the legislature is serious about moving forward so those kinds of questions are answered.

Comment: Consumers and family members have raised concerns about the level of their involvement in the workgroup membership. Will more workgroup members be added?

Legislator Response: DHS has heard those concerns and is working to identify the best way to provide a greater role and more consumer and family input into the process, but it won't necessarily be through adding workgroup members. It is important that peoples' voices are heard and incorporated and DHS is working hard to do so.

Comment: This group has a tough project and the most important thing on the list is a locus of accountability. This is a system involving more than $1 billion and legislators want to see how we as a state are getting value for that investment. Systems like Blue Cross and Blue Shield and Medicaid are large and pervasive and have resources and efficiencies. The legislature wants tools of accountability for this system. Can we create a strong enough entity on a regional level to do what the managed care structure does? Keep in mind that it has to be accountable and deliver the services in the environment we want; it is terribly important to the people we serve.

Comment: Three points: 1. Even though our system of funding streams is now very complex, consumers don't see that complexity. 2. The $1 billion figure just mentioned includes all the social security people in the State receive. 3. The legislature has repealed the system but not the mandates. The mandates are going to have to be moved to the regions or they are going to have to become something new and different.

Comment: Consistency is one of the mantras, but consistency can mean being consistently good or consistently bad. As a system we have come a long way. The Olmstead Plan is the driving force and underlying philosophy for everything that every workgroup is doing. We are striving to achieve a true partnership between people who are receiving services, family members, provider agencies, and the general community. We are striving to pull together a creative system. Are we looking at a different system in terms of structure and players for the intellectual and developmental disability system and the mental health system? I hear a lot of discussion about mental health, but not about service providers to the ID/DD population.

DHS Response: That is a fair observation of the way law is drafted, but the reality is that a majority of people served at the local level are in the ID/DD system and a significant proportion of Medicaid funding is for that population. We could not talk about a regional system for mental health that does not also include intellectual and developmental disabilities. It is more a matter of the history of the bill than what needs to happen in both systems. The current county governance structure has dealt with both. The amount of co-occurring need is great and must be taken into account.

Note: The next meeting will be extended until 3:15 pm to allow 30 minutes for public comment.

For more information:

Handouts and meeting information for each workgroup will be made available at: http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.